

# Eli's Rehab Report

## 5 Easy Steps to Fluoroscopy Reimbursement

According to CMS, physiatrists reported the fluoroscopic guidance code 76005 nearly 25 times more frequently than they reported any other fluoroscopy code in 2001. Despite the code's popularity, however, many practices have difficulty collecting payment for their fluoroscopic guidance services when performed with epidural injections. The following five steps can help your practice collect appropriate fluoroscopy reimbursement.

Several subscribers report that their carriers deny fluoroscopic guidance (76005, Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint], including neurolytic agent destruction) and bundle it into the following epidural injection codes:

1. [CPT 62310](#) - Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
2. [CPT 62311](#) - ... lumbar, sacral (caudal).

The National Correct Coding Initiative (NCCI) does not include any edits barring practices from reporting the fluoroscopic guidance and epidural injection codes together, so you should inspect your claim to ensure that you submitted it correctly. And if you did, you should appeal the denial.

### Step One: Confirm Your Guidance Code

Although 76005 is the appropriate fluoroscopic guidance code to submit with epidural injection claims, some coders still report 76000 (Fluoroscopy [separate procedure], up to one hour physician time, other than 71023 or 71034 [e.g., cardiac fluoroscopy]) instead.

"CPT 2000 introduced 76005 as the new code for fluoroscopy with spinal injections, leaving 76000 for use in more comprehensive surgeries," says **Julie Jarvis**, owner of Underwood Billing, a coding and billing firm in Orlando, Fla. "Unfortunately, some practices are following old advice and are still reporting 76000 with 62310 and 62311."

Coders who are new to epidural injection billing might refer to outdated LMRPs or back issues of CPT Assistant to support billing 76000 with their epidural claims. The December 1998 CPT Assistant, for example, advised practices to report 76000 with epidural injections. More recent issues of the publication have updated this advice to reflect the more accurate code 76005, but some coders don't realize that and are still following the obsolete advice.

### Step Two: Confirm Your Carrier's Guidelines

Even if you submit your claim with the appropriate fluoroscopic guidance code (76005), your carrier may think you've used the incorrect fluoroscopy code. "Believe it or not, there are still insurers out there that haven't updated their systems since 2000," Jarvis says. In addition, "it's not that unusual for workers' compensation or other private insurers to still require 76000 instead of 76005. Remember that private payers can and do make their own rules when it comes to the codes they prefer you to report," she says.

Confirm that your Medicare carrier has updated its system to reflect 76005's addition and that your private payers require 76005 instead of a different fluoroscopy code with your epidural claims.

### Step Three: Check for Documentation of Formal Contrast Study

When billed with epidural injections, Medicare payers will reimburse you either for fluoroscopy or for a formal contrast study, but not both. The LMRP for Palmetto GBA, a Part B carrier in South Carolina, states, "Fluoro-scopic guidance and localization is reported by CPT code 76005, unless a formal contrast study is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes." To report a formal contrast study, such as an epidurogram or myelogram, the physician must write a formal radiological report. The following codes apply to contrast studies that PM&R practices perform with epidural injections:

3. 72240 - Myelography, cervical, radiological supervision and interpretation
4. 72255 - Myelography, thoracic, radiological supervision and interpretation
5. 72265 - Myelography, lumbosacral, radiological supervision and interpretation
6. 72270 - Myelography, entire spinal canal, radiological supervision and interpretation
7. 72275 - Epidurography, radiological supervision and interpretation.

See the chart "Fluoroscopy Cheat Sheet" on page 67 for more information on when you can report formal contrast studies and when you should bill for fluoroscopic guidance instead.

#### **Step Four: Determine Whether -26 Is Required**

The Physician Fee Schedule includes relative value units for the professional and technical components of 76005. Therefore, if the physician does not own the fluoroscopy equipment, you should append modifier -26 (Professional component) to the fluoroscopy code, says **Kathy Pride, CPC, CCS-P**, HIM applications specialist and coding and reimbursement expert with Quadramed, a California-based consulting firm. Medicare will reimburse the facility or hospital for the claim's technical portion and will pay you for the professional component.

#### **Step Five: Appeal**

If your claims pass muster on our first four steps, and Medicare still denies your claim, you should appeal. Send your carrier a copy of the NCCI edits, which demonstrate that 76005 is not a component of 62310 and 62311. In addition, if your LMRP provides specific direction on epidural injections with fluoroscopic guidance, you should send a copy of the policy and highlight the portion that directs you to report 76005 with epidural injections. The physiatrist should write a short appeal letter, and you should send the claim as a "hard-copy claim" instead of electronically.